Application to Become a Provider of Medicaid Reimbursed Mental Health and Addictive Diseases Rehabilitation Option Services

and/or

Mental Retardation and Developmental Disabilities Home and Community Based Waiver Services

Georgia Department of Human Resources

Division of Mental Health, Developmental Disabilities, and Addictive Diseases

June 1, 2004

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Introduction

This manual is for:

- Prospective new providers
- Current providers requesting:
  - New services at a currently established site
  - New services at a new site
  - An address change

The application contained in this manual has 3 sections:

- Section I is for all prospective new providers.
- Section II is for prospective new providers and current providers who offer mental health and addictive disease services.
- Section III is for prospective new providers and current providers who offer mental retardation and developmental disabilities services.

You can submit your application to:

Division of MHDDAD
Systems Design and Medicaid Coordination Section
ATTN: Medicaid APPLICATION PROCESSING
2 Peachtree Street, NW
23rd Floor, Suite 23-247
Atlanta, GA 30303

Information for Prospective New Providers

Directions, helps, and hints on becoming an MHDDAD Medicaid service provider

You are about to make application to become a Medicaid-reimbursed Service Provider for the Division of Mental Health, Developmental Disabilities and Addictive Diseases (DMHDDAD).

It is the responsibility of the Division of MHDDAD to assure that providers of services to consumers are financially qualified and are competent to provide these services. Thus the application process is detailed and lengthy.

Here are some things to think about before you begin the process of completing the application:

- Know what services you are planning to provide.
- Review the qualifications for providing the service(s) you wish to provide.
    - Make sure you can meet these requirements.
- Review the application directions and documentation that is required
- Complete all sections of the application, including documentation that is required.
- Submit all required information in a 3-ring binder.
    - Put the required documentation in the binder behind a tab labeled with each item required. Use the application checklist located in Appendix C to organize the items in your binder.
    - Tab the required documentation according to the order of items listed on the application checklist.
- Your agency must have Internet capacity and active e-mail.

When you are satisfied that you have completed all requirements of the application, submit 2 copies of your application, each in a 3-ring binder to:

Division of MHDDAD
Systems Design and Medicaid Coordination Section
ATTN: Medicaid APPLICATION PROCESSING
2 Peachtree Street, NW
23rd Floor, Suite 23-247
Atlanta, GA 30303

BE SURE TO KEEP A FULL COPY OF YOUR APPLICATION FOR YOURSELF.

Conditions of Participation for Medicaid Reimbursed Services

Mental Health/Substance Abuse Service Providers

The State has two categories of mental health/substance abuse rehabilitation option providers:

- **Comprehensive community mental health center.** Comprehensive providers are required to serve all age groups with mental illness and/or addictive disease issues. Services included in the comprehensive array are interrelated and therefore should be provided by a single entity for promotion of a comprehensive and coordinated service benefit. Enrolled providers must provide all services identified in the comprehensive array. *(The list of services in the comprehensive array is on the next page.)*

- **Specialty mental health substance abuse provider.** Specialty services may be provided by either comprehensive providers or providers who only provide one or a group of specialty services. A specialty provider is defined as an entity that meets all of the conditions of participation for a specialty provider and that meets the qualifications for the specific requested service.

Any entity wishing to become a Mental Health/Substance Abuse provider reimbursed by Medicaid must meet the following requirements:

- DMA policies and procedures established in Part I and in Part II for Community Mental Health Centers (CMHC) *(available at www.ghp.georgia.gov)*
- Requirements of the DHR/MHDDAD provider manual
    - Pay particular attention to Core Standards
- Service provision according to service descriptions as outlined in the State of Georgia Medicaid Community Mental Health Center (CMHC) Provider Manual *(available at www2.state.ga.us/departments/dhr/mhmrsa/index.html)*
- Staff credentialing requirements (included in the Medicaid CMHC Provider Manual)
- Licensure requirements in accordance with the rules and regulations of the State and DHR (included in the Medicaid CMHC Provider Manual)
- Maintains such records as are necessary to fully disclose the extent of services provided and to furnish the Department of Medical Assistance or the DHR/MHDDAD with information as may be requested
- Assures a billing system to appropriately identify and bill all liable third parties.
- Agrees to participate in and provide services authorized by the Department's external review organization

Comprehensive Community Mental Health Center Rehabilitation Option

An entity that meets the following conditions of participation may apply to be a rehabilitation option comprehensive community mental health center.

- Assure that **ALL** the following services are furnished and all are under the authorization of a physician, or other authorizing professional as specifically defined in the State of Georgia Community Mental Health Center Provider manual. (See the Medicaid CMHC Provider Manual.)

    - Activity Therapy
    - Ambulatory Detox
    - Child and Adolescent Day Supports
    - Child and Adolescent Day Treatment
    - Community Support Individual
    - Community Support Team
    - Crisis Residential Services
    - Diagnostic Assessment
    - Family Counseling and Training
    - Group Counseling and Training
    - In-Clinic Crisis Management
    - Individual Counseling
    - Intensive Day Treatment
    - Medication Administration
    - Nursing Assessment and Health Services
    - Occupational Therapy
    - Out-of-Clinic Crisis Management
    - Physical Therapy
    - Physician Assessment and Care
    - Specialized Adolescents Substance Abuse Day Treatment
    - Speech and Hearing Therapy
    - Substance Abuse Day Treatment

If you do not plan to provide <u>ALL</u> of the services listed above in accordance with the stated requirements, you are not eligible to become a Comprehensive provider.

Specialty Mental Health/Substance Abuse Provider Rehabilitation Option

An entity that meets the following conditions of participation may apply to be a rehabilitation option specialty mental health/substance abuse provider.

- Meet the organization and service requirements set forth by DMHDDAD for providing one or more of the following services:
  - Adult Peer Supports
  - Assertive Community Treatment
  - Intensive Family Intervention
  - Psychosocial Rehabilitation
  - Rehabilitative Supports for Individuals in Residential Alternatives I
  - Rehabilitative Supports for Individuals in Residential Alternatives II
- Assure that all services are furnished under the authorization of a physician, or other authorizing professional as specifically defined in the State of Georgia Community Mental Health Center Provider manual. (See the Medicaid CMHC Provider Manual.)
- Maintains such records as are necessary to fully disclose the extent of services provided and to furnish the Department of Medical Assistance or the DHR/MHDDAD with information as may be requested.
- Assures a billing system to appropriately identify and bill all liable third parties.
- Agrees to participate in and provide services authorized by the Department's external review organization.

Any concerns? Contact the Regional Office in the region where you wish to provide services if you have questions. The contact information on the regional offices is located at www2.state.ga.us/departments/dhr/mhmrsa/index.html.

Mental Retardation/Developmental Disabilities Service Providers

The State has two Home and Community Based Waivers for services to individuals with mental retardation/developmental disabilities. The services provided under the two waivers are the same. The differences between the two waivers are the payment for services and the provider selection process.

- **The Mental Retardation Waiver Program (MRWP)**, the older and larger of the two waivers, is a fee-for-service waiver and is open to any **qualified** willing provider.

- **The Community Habilitation and Support Services Waiver (CHSS)** is a bundled rate waiver, and providers are selected via a competitive procurement process. *This option is not included in this packet.*

To be eligible for waiver services, a consumer must meet the level of care requirements for an Intermediate Care Facility for Mental Retardation (institutional). Once eligible, services are provided based on availability of funds allocated by the General Assembly. All services provided under the waiver must be medically necessary, and prior approval by the regional office is required.

Any entity wishing to become a Mental Retardation/Developmental Disability provider reimbursed by Medicaid must meet the following requirements:

- DMA policies and procedures established in Part I and in Part II for the Mental Retardation Waiver Program (available at www.ghp.georgia.gov)
- Requirements of the DHR/MHDDAD provider manual
  - Pay particular attention to the core Standards
- Staff credentialing requirements as required through licensure and/or specified in the Medicaid Policy and Procedure Manual
- Licensure requirements in accordance with the rules and regulations of the State and DHR
- Maintains such records as are necessary to fully disclose the extent of services provided and to furnish the Department of Medical Assistance or the DHR/MHDDAD with information as may be requested
- Assures a billing system to appropriately identify and bill all liable third parties
- Agrees to participate in and provide services authorized by the DHR's external review organization

Mental Retardation Waiver Program (MRWP)

An entity that meets the following conditions of participation may apply to be a Medicaid reimbursed mental retardation/developmental disabilities services provider.

- Meet the organization and service requirements set forth by DMHDDAD for providing one or more of the following services:

    - Day Habilitation
    - Day Supports
    - Environmental Modifications
    - Natural Support Enhancement Services
    - Natural Support Therapy Services
    - Personal Support Services
    - Residential Training and Supervision
    - Respite
    - Specialized Medicaid Equipment
    - Specialized Medical Supplies
    - Support Employment
    - Vehicle Adaptations

- Agree to fully participate in the assessment/reassessment and service planning for consumers convened by the Intake and Assessment vendor in the region
- Agree to fully cooperate with the Support Coordination Agency assigned to the consumers in service with the agency
- Agree to provide services in accordance with the approved service plan and prior authorized by the Regional Office

Any concerns? Contact the Regional Office in the region where you wish to provide services if you have questions. The contact information on the regional offices is located at www2.state.ga.us/departments/dhr/mhmrsa/index.html.

Securing a Contract or Letter of Agreement

Contracts and agreements for consumer services are made and entered into by and between the Department of Human Resources through its Division of Mental Health, Developmental Disabilities and Addictive Diseases.

Meeting all of the requirements to be an approved provider DOES NOT AUTOMATICALLY INSURE that you will be awarded a contract or letter of agreement. For example, if there are not enough dollars to purchase your services you will not be awarded a contract. Your application will be noted as approved and maintained on file.

DO NOTE that all providers of direct consumer services who receive $250,000 or more dollars authorized by the state are required to be accredited by one of the following accrediting bodies:

- The Council on Accreditation of Rehabilitation Facilities (CARF)
- The Council on Accreditation of Services for Families and Children (COA)
- The Council on Quality and Leadership (CQL)
- The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Additionally, all providers of direct consumer services who receive less than $250,000 dollars authorized by the state are required to obtain certification from the Division.

If you do not hold national accreditation or state certification and you are awarded a contract or LOA, here is what you must do:

- You must submit evidence of application for accreditation or certification within the first SIX months of your contract or LOA

- You must SUCCESSFULLY ACHIEVE accreditation or certification within the first TWELVE months of your contract or LOA

In the interim, staff from the regional office representing the Division will conduct reviews of your progress every 90 days (refer to Division Policy 9:100, *Provider Requirements for Accreditation and Certification*). Failure to comply with these accreditation/certification requirements may result in revocation of the Medicaid Provider Number and potential recouping of dollars paid out under this agreement.

Medicaid Provider Application

The Medicaid provider application is divided into three sections:

- Section I is to be completed by all prospective new providers.
- Section II is to be completed by prospective new providers and current providers who offer mental health and addictive disease services.
- Section III is to be completed by prospective new providers and current providers who offer mental retardation and developmental disabilities services.

The DHR application review process from start to finish is time consuming. DMHDDAD performs a number of checks to insure that the integrity of the mental health, developmental disabilities and addictive disease provider pool is maintained. From the date the application is received by the Systems Design and Medicaid Coordination Section, it will take at a minimum six months for the application process to be completed. Please be mindful of this at the beginning of your application process and remember the time can be longer if incomplete or incorrect information is provided on the application. The regional office staff and division staff are available to provide technical assistance to you throughout this process but they cannot assist you in completing the application. You can find the regional office contact information at www2.state.ga.us/departments/dhr/mhmrsa/index.html.

It should also be noted that a completed application and assignment of a provider number from the Department of Community Health is not the end of the process. You must also have a Letter of Agreement with the Regional Office in each region where you wish to do business. It is also important that you understand none of these steps guarantees you referrals of consumers to your agency for you to serve. Providers of services to consumers are based on consumer choice and availability of funding.

Submit your application to:

Division of MHDDAD
Systems Design and Medicaid Coordination Section
ATTN: Medicaid APPLICATION PROCESSING
2 Peachtree Street, NW
23rd Floor, Suite 23-247
Atlanta, GA 30303

Medicaid Provider Application

SECTION I

Section I of the application is to be completed by all prospective new providers.

1. Organization Legal Name: _____

_____

2. Street address: _____

_____

3. Mailing Address, *if different*: _____

_____

4. CEO/Director Name: _____

5. Contact Name: _____

Telephone_____Fax_____

E-mail address_____

6. EIN *(Employer ID Number)*_____ *(You can apply for an EIN at www.irs.gov/businesses.)*

7. Recorded with Secretary of State, State of Georgia? ☐Yes ☐No
(Corporation must be recorded with the Georgia Secretary of State to do business in the State of Georgia. The SOS may be contacted by phone at 404-656-2817 or at http://www.sos.state.ga.us/ to verify information)

8. Are you currently or have you been (within the past 24 months) a subcontractor for an MHDDAD service provider? If yes, complete the form below. List contractor names, address, contact person, and specify service you provided for the contractor. Use additional pages as required. Include a letter of reference from each contractor in your attachments.

*Contractor Name	Contractor Address	Contact Person	Service

Include a letter of reference from each contractor in your attachments.

List any and all provider number(s) issued to the agency with corresponding service and the region in which services are provided. Use additional pages if necessary. Regions will be contacted for information.

Medicaid Number	Service Provided and License Number (if applicable)	Region

9. Indicate the region or regions where you will operate: _____
(See the map of regions in Appendix D.)

Under penalty for perjury, I do hereby swear or affirm that I am the authorized agent to complete this application and that the information contained in this application is complete, true, and correct.

Printed Name of Applicant	Printed Name of Agency
Signature of Applicant	Date

Sworn to before me this_____ day of _____ , _____

Notary Public	Seal Required
Commission Expires	

Provide the following information or documentation as attachments to your application.

Organizational Information

1. Will this be a corporate management contract? If so, specify:
   a. Name of the corporation
   b. Address of the corporation headquarters
   c. Name of the chief operating officer
   d. Contact person including telephone and fax numbers

2. If this organization is a subsidiary of a corporate board, or if this organization has subsidiaries, specify name(s) and addresses

3. Curriculum Vitae for the Georgia operations CEO / Director, including professional license number (if any)

4. Work history for the most recent 5 years for the Georgia CEO / Director

5. Names and professional titles, if any, of persons serving on the Georgia governing board OR names and professional titles, if any, of persons serving on the Georgia advisory committee for the agency

6. Plan for oversight by the governing board or advisory committee, including role and responsibility in governance of the agency, frequency of meetings, etc.

7. Organizational chart for the Georgia agency. Show corporate lines of authority (if applicable) to local management and direct service staff. Include the following information for all persons filling positions noted on the organizational chart:
   a. Name
   b. Position
   c. Required qualifications for the position
   d. Relationship to the CEO / Director / Owner of the agency
   e. Education
   f. Work history for the most recent 5 years
   g. Professional license (if any)

Revenues

8. Financial statements for the previous three fiscal years (indicate agency's fiscal year dates), prepared in conformity with generally accepted accounting principles and audited in conformity with generally accepted auditing standards. If a new service provider, pro forma bank statement (current within 30 days) with cash flow projections for the first fiscal year

9. Listing, by category and amount, of the sources of revenue for the organization not made available within the financial statements (private donations, donations from charitable organizations, public fund sources, etc.)

10. If a nonprofit organization, include a copy of your 501 (c) (03) letter and a listing of each employee currently employed and his or her salary and reimbursable expenses if such information is not available within the submitted financial statements

Accreditation/Licensure/Certification

11. Evidence of national accreditation (approved by the Division of MHDDAD) or certification by the Division of MHDDAD, if already providing services to clients

12. Applicable license or certification for each service site, if applicable

Insurance

13. Evidence of liability insurance, including agency vehicles

Services

14. Description of each proposed service, the plan for delivering that service and the service locations (counties and regions). Include your philosophy of service, the therapeutic model you use, and how you make your services accessible--including your hours of operation.

Staffing

15. Completed Form 1, Organization Staffing Roster, *located in Appendix A of this manual*

Plans

16. Continuous Quality Improvement (CQI) plan, including identified risk activities and plans to assess risk activities. Address the processes you will use, how teams and staff will be involved, and how results will be summarized and reported.
17. Disaster plan, including environmental emergencies.
18. Statement of client rights and responsibilities, including plan for review and acknowledgment by client
19. Plan for protection of clients from abuse, neglect or exploitation

Policies and Procedures

20. Policy and procedures for reporting and investigating serious and unusual incidents and for documentation, follow-up and administrative review
21. Policy and procedures for consumer complaints and grievances. Include a description for filing consumer complaints and grievances as well as a description for receiving, considering, and resolving consumer complaints and grievances.
22. Policy and procedures for medication management. Address the administration of medications including self-administration, the storage of medications, and the disposal of outdated medications.
23. Policy and procedures on confidentiality. Address how you will assure the confidentiality of consumer information contained in records, charts, documents, and any other forms.
24. Policy and procedures on handling the death of a consumer. Death includes all suicides as well as a death occurring within 2 weeks following the consumer's discharge from a community residential provider AND the death of any consumer transferred or discharged to a medical facility for treatment of any illness or injury that occurred during community provider custody, regardless of the time that has elapsed since the transfer or discharge.
25. Policy and procedures for clinical records management, including a plan for securing confidential consumer information.

Letters of Reference

26. Letters of reference from contractors (if applicable).

Section II

Application for Mental Health and Addictive Diseases Service Provision

Categories of Applicants

Providers are divided into categories, and requirements for application to this community mental health center program differ depending on the category. Requirements for each category are listed below.

New Provider

The applicant must submit all of the items listed below. **See the application checklist *located in Appendix C* for how the items should be organized for submission.**

- Application to Provide Mental Health, Developmental Disabilities and Addictive Disease Services and Medicaid Provider Number Application, *located in Section I of this manual.*

- The following forms *located in Appendix A of this manual*:

    - Form 1: Organization Staffing Roster
        - Direct care staff
        - Licensed Clinicians/Staff
    - Form 2: Organization Staffing Roster Mental Health Professionals
    - Form 3: Specialty Provider of Rehabilitation Services Certification Regarding Service Authorization
    - Form 4: Community Mental Health Centers Request for New Site/New Service
    - Form 5: Community Mental Health Centers Request for New Site/New Service Procedure Codes and Services

- Georgia Division of Medical Assistance "Provider Enrollment Application Package" *available at www.ghp.georgia.gov/wps/portal.*

    - Provider Enrollment Application (DMA-001)
    - Statement of Participation (DMA-002)
    - Request for Taxpayer Identification and Certification
    - Disclosure of Ownership and Control Interest Statement
    - Electronic Funds Transfer Agreement (DMA-405)
    - Provider Electronic Funds Transfer Information (DMA-406)
    - Power of Attorney for Electronic Data Interchange – optional
    - Power of Attorney for Payee – optional

Current Provider – Requesting new services at a currently established site
The applicant must submit 2 copies of the items listed below.

- Cover page – *Use the form provided in Appendix B.*

- Signed and notarized statement attesting that information contained in the application is true and that the signatory is the authorized agent to complete the application – *Use the form provided in Section I of the application.*

- The following forms *located in Appendix A of this manual:*

    - Form 1: Organization Staffing Roster
    - Form 4: Community Mental Health Centers Request for New Site/New Service
    - Form 5: Community Mental Health Centers Request for New Site/New Service Procedure Codes and Services

- Description of each proposed service, the plan for delivering the service, and the accessibility of the service including hours of operation.

Current Provider – Requesting new services at a new site
The applicant must submit 2 copies of the items listed below.

- Cover page - *Use the form provided in Appendix B.*

- Signed and notarized statement attesting that information contained in the application is true and that the signatory is the authorized agent to complete the application – *Use the form provided in Section I of the application.*

- The following forms *located in Appendix A of this manual*:

    - Form 1: Organization Staffing Roster
    - Form 4: Community Mental Health Centers Request for New Site/New Service
    - Form 5: Community Mental Health Centers Request for New Site/New Service Procedure Codes and Services

- Description of each proposed service, the plan for delivering the service, and the accessibility of the service including hours of operation.

Current Provider – Requesting new services at a new site *(continued)*

- Georgia Division of Medical Assistance "Provider Enrollment Application Package" *available at www.ghp.georgia.gov/wps/portal.*

    - Provider Enrollment Application (DMA-001)
    - Statement of Participation (DMA-002)
    - Request for Taxpayer Identification and Certification
    - Electronic Funds Transfer Agreement (DMA-405)
    - Provider Electronic Funds Transfer Information (DMA-406)
    - Power of Attorney for Electronic Data Interchange – optional
    - Power of Attorney for Payee – optional

Current Provider – Requesting an address change
The applicant must submit the following item:

- Memo to Community Mental Health Program Specialist, Division of Medical Assistance, **copied to the Division of MHDDAD**, which articulates the site from which the agency is moving services and the site to which the agency is moving services. This memo must include an effective date.

Submit your application to: Division of MHDDAD
Systems Design and Medicaid Coordination Section
ATTN: Medicaid APPLICATION PROCESSING
2 Peachtree Street, NW
23rd Floor, Suite 23-247
Atlanta, GA 30303

Section III

Application for Mental Retardation Home and Community Based Services Waiver Service Provision

Categories of Applicants

Providers are divided into categories, and requirements for application to this community based services program differ depending on the category. Requirements for each category are listed below.

New Provider

The applicant must submit all of the items listed below. **See the application checklist *located in Appendix C* for how the items should be organized for submission.**

- Application to Provide Mental Health, Developmental Disabilities and Addictive Disease Services and Medicaid Provider Number Application, *located in Section I of this manual.*

- The following forms *located in Appendix A of this manual*:

    - Form 1: Organization Staffing Roster
        - Direct care staff
        - Licensed Clinicians/Staff
    - Form 6: Mental Retardation Home and Community Based Services Waiver Request for New Site/New Service Procedure Codes and Services
    - Form 7: Mental Retardation Home and Community Based Services Waiver Request for Proposed Services and Locations

- Your agency's plan of care for physical health issues for individuals in service with your agency, including:

    - Routine health care
    - Emergency health care
    - Name, address, phone number and medical specialty of primary health care provider for your agency

New Provider *(continued)*

- Your agency's plan of care for behavioral health issues, emphasizing promotion of constructive behaviors, and including plan for:

    - Routine consultation
    - Immediate support
    - Name, address, phone number and specialty of behavioral health care provider for your agency

- Georgia Division of Medical Assistance "Provider Enrollment Application Package" *available at www.ghp.georgia.gov/wps/portal.*

    - Provider Enrollment Application (DMA-001)
    - Statement of Participation (DMA-002)
    - Request for Taxpayer Identification and Certification
    - Disclosure of Ownership and Control Interest Statement
    - Electronic Funds Transfer Agreement (DMA-405)
    - Provider Electronic Funds Transfer Information (DMA-406)
    - Power of Attorney for Electronic Data Interchange – optional
    - Power of Attorney for Payee – optional

Current Provider – Requesting new services at a currently established site
The applicant must submit 2 copies of the items listed below.

- Cover page - *Use the form provided in Appendix B.*

- Signed and notarized statement attesting that information contained in the application is true and that the signatory is the authorized agent to complete the application – *Use the form provided in Section I of the application.*

- The following forms *located in Appendix A of this manual:*

    - Form 1: Organization Staffing Roster
    - Form 6: Mental Retardation Home and Community Based Services Waiver Request for New Site/New Service Procedure Codes and Services

- Description of each proposed service, the plan for delivering the service, and the accessibility of the service including hours of operation.

Current Provider – Requesting new services at a new site
The applicant must submit 2 copies of the items listed below.

- Cover page - *Use the form provided in Appendix B.*

- Application to Provide Mental Health, Developmental Disabilities and Addictive Disease Services and Medicaid Provider Number Application, *located in Section I of this manual.*

- The following forms *located in Appendix A of this manual*:

    - Form 1: Organization Staffing Roster
    - Form 6: Mental Retardation Home and Community Based Services Waiver Request for New Site/New Service Procedure Codes and Services
    - Form 7: Mental Retardation Home and Community Based Services Waiver Request for Proposed Services and Locations

- Description of each proposed service, the plan for delivering the service, and the accessibility of the service including hours of operation.

- Georgia Division of Medical Assistance "Provider Enrollment Application Package" *available at www.ghp.georgia.gov/wps/portal.*

    - Provider Enrollment Application (DMA-001)
    - Statement of Participation (DMA-002)
    - Request for Taxpayer Identification and Certification
    - Electronic Funds Transfer Agreement (DMA-405)
    - Provider Electronic Funds Transfer Information (DMA-406)
    - Power of Attorney for Electronic Data Interchange – optional
    - Power of Attorney for Payee – optional

Current Provider – Requesting an address change
The applicant must submit the following item:

- Memo to Home and Community Based Waiver Program Specialist, Division of Medical Assistance, **copied to the Division of MHDDAD**, which articulates the site from which the agency is moving services and the site to which the agency is moving services. This memo must include an effective date.

Appendix A

Forms

Form 1. Organization Staffing Roster – *Complete both pages*

List all positions involving direct care staff (i.e., therapists, support staff, peer specialists, etc.) with the corresponding skills required for the position.

POSITION TITLE	BRIEF POSITION DESCRIPTION	SKILLS REQUIRED

Licensed/Certified Clinicians/Staff – *Attach a copy of each license or certification*

Name	Position Title	% Time with Agency	License/ Certification Number	Licensure/ Certification Period

Form 2. Organization Staffing Roster Mental Health Professionals

NAME	POSITION TITLE	% TIME WITH AGENCY	DATE OF MHP DESIGNATION

Form 3. Specialty Provider Of Rehabilitation Services Certification Regarding Service Authorization

In the Georgia Department of Human Resources' Medicaid Community Mental Health Center Manual, the Staff Qualifications Section requires that only certain Licensed Clinicians may authorize Rehabilitation Services (see Section 4 of that manual *available at www2.state.ga.us/departments/dhr/mhmrsa/index.html*). Consistent with that requirement, I do hereby certify that the organization that is seeking to become a provider of Medicaid Rehabilitation Option services, and on whose behalf I'm acting, will only allow the appropriate Licensed Clinicians to authorize Rehabilitation Services.

_____
Signature

_____
Name

_____
Title

_____
Date

FORM 4. Community Mental Health Centers
Request For New Site/New Service

1. Please provide the street address of the new service site below.

Agency Name

Street Address City Zip Code

2. Please list each service that will be provided at the new site below (see codes attached)

Procedure Code	Capacity (clients served per day)	Expected Medicaid recipients daily

3. Are you currently accredited by a national organization? ____ Yes ____No
If yes, please attach a certificate of accreditation from a national accrediting organization. If no, please attach DMHDDAD certification or DMHDDAD pre-certification memo. **Applications without this documentation will not be considered.**

4. If you are a current Medicaid Rehab Option provider, are you (Check one)
____ expanding service locations?
____ moving existing services to a new location?

What services are you discontinuing and replacing with this request, if any?

Location Discontinued	New Location	New Procedure code	Discontinued Procedure Code	Provider Number

5. For Questions 1 and 2, please identify which county(s) these sites will serve.

_____

_____

FORM 5: Community Mental Health Centers
Request For New Site/New Service
Procedure Codes And Services

Provider Name: _____

Address of Site: _____

_____

COMPREHENSIVE PROVIDERS ONLY

Enrollment is requested at the designated site for each new Procedure Code checked below, with Effective date, _____/_____/_____			DHR Use Only
Requested			Approved
	Y3000	Diagnostic Assessment	
	Y3001	Intensive Day Treatment (Partial Hospitalization)	
	Y3005	Ambulatory Detoxification	
	Y3006	Nursing Assessment and Health Services	
	Y3007	Physician Assessment and Care	
	Y3008	Physical Therapy	
	Y3009	Speech and Hearing Therapy	
	Y3010	Occupational Therapy	
	Y3011	Activity Therapy	
	Y3012	Medication Administration	
	Y3013	In-Clinic Crisis Management	
	Y3027	Out-of-clinic Crisis Management	
	Y3014	Family Training/Counseling	
	Y3015	Group Training and Counseling	
	Y3016	Individual Counseling	
	Y3018	Child and Adolescent Day Treatment	
	Y3025	Child and Adolescent Day Supports	
	Y3020	Specialized Adolescent Substance Abuse Day Treatment	
	Y3026	Substance Abuse Day Services	
	Y3028	Crisis Residential Services	
	Y3030	Community Support Individual	
	Y3036	Community Support Team	

PROVIDERS OF SPECIALTY SERVICES ONLY

Enrollment is requested at the designated site for each new Procedure Code checked below, with Effective date, _____/_____/_____			DHR Use Only
Requested			Approved
	Y3022	Adult Peer Support	
	Y3032	Psychosocial Rehabilitation	
	Y3033	Intensive Family Intervention	
	Y3031	Assertive Community Treatment	
	Y3035	Residential Rehabilitative Supports II	
	Y3034	Residential Rehabilitative Supports I	

_____ _____
Authorized Signature – **Provider** Date

On Behalf of the GA Department of Human Resources, I certify that the services marked "Approved" by a ☑ in column 4 above have been reviewed and approved by the Division of MH, DD and AD in keeping with the provider application and certification process.

_____ _____
DMHDDAD Representative* Signature

**This statement is signed after your application is submitted to DMHDDAD.*

FORM 6: Mental Retardation Home and Community Based Services Waiver Request For New Site/New Service Procedure Codes And Services – *Complete both pages of the form*

Provider Name: _____

Providers' Business Address: _____

_____

Requested Yes/No	Service Code	Service Name	Address of Service Site	DHR USE ONLY Approved
	Y3300	Residential Training and Support		
	Y3341	Day Supports		
	Y3316	Supported Employment		
	Y3007	Day Habilitation		
	Y3308	Respite I/Daily		
	Y3312	Respite I/Hourly		
	Y3309	Respite II/Daily		
	Y3313	Respite II/Hourly		
	Y3310	Respite III/Daily		
	Y3314	Respite III/Hourly		
	Y3311	Respite IV/Daily		
	Y3315	Respite IV/Daily		
	Y3319	Personal Support Services		
	Y3343	Natural Support Enhancement Services		
	Y3344	Natural Support Therapies		
	Y3320	Environmental Modification		
	Y3321	Vehicle Adaptations		
	Y3323	Specialized Medical Equipment		
	Y3322	Specialized Medical Supplies		

FORM 6
Page 2

_____ _____
Authorized Signature – **Provider** Date

On Behalf of the GA Department of Human Resources, I certify that the services marked "Approved" by a ☑ in column 4 above have been reviewed and approved by the Division of MH, DD and AD in keeping with the provider application and certification process.

_____ _____
DMHDDAD Representative* Signature

Approval Effective Date: _____

**This statement is signed after your application is submitted to DMHDDAD.*

Form 7: Mental Retardation Home and Community Based Services Waiver
Proposed Services and Locations

Proposed Service	Service Location	Subcontract (Yes/No)

Use additional pages as needed.

Appendix B

Cover Page

Medicaid Provider Application

Cover Page

Organization Name: _____

Street Address: _____

_____

Mailing Address: _____
(if different)

_____

CEO/Director Name: _____

Contact Name: _____
Telephone: _____ **Fax:** _____
E-mail address: _____

- ❑ Prospective new provider
- ❑ Current provider requesting
  - ❑ New services at a currently established site
  - ❑ New services at a new site

- ❑ Mental Health/Addictive Diseases Services
- ❑ Mental Retardation/Developmental Disabilities Services

Appendix C

New Provider
Application Checklists

- **New provider of mental health and addictive diseases services**
- **New provider of mental retardation and developmental disabilities services**

New Provider of Medicaid Reimbursed
Mental Health and Addictive Diseases Rehabilitation Option Services
Application Checklist

- ❑ 2 copies of your application, each in a 3-ring binder, sized appropriately to the documents submitted organized as follows:
- ❑ Cover page
- ❑ Form 4: Community Mental Health Centers Request for New Site/New Service
- ❑ Tab: Georgia Division of Medical Assistance "Provider Enrollment Application Package"
  - ❑ Provider Enrollment Application (DMA-001)
  - ❑ Statement of Participation (DMA-002)
  - ❑ Request for Taxpayer Identification and Certification
  - ❑ Disclosure of Ownership and Control Interest Statement
  - ❑ Electronic Funds Transfer Agreement (DMA-405)
  - ❑ Provider Electronic Funds Transfer Information (DMA-406)
    - ❑ Voided check or bank specification sheet attached
  - ❑ Optional forms
    - ❑ Power of Attorney for Electronic Data Interchange
    - ❑ Power of Attorney for Payee
- ❑ Tab: Application to Provide Mental Health, Developmental Disabilities and Addictive Disease Services
  - ❑ Section 1: Application Form
    - ❑ Signed and notarized
- ❑ Tab: Mental Health and Addictive Diseases Service Provision Forms
  - ❑ Form 2: Organization Staffing Roster Mental Health Professionals
  - ❑ Form 5: Community Mental Health Centers Request for New Site/New Service Procedure Codes and Services
    - ❑ Signed by a regional staff member in a management position
  - ❑ Form 3: Specialty Provider of Rehabilitation Services Certification Regarding Service Authorization
- ❑ Tab: Attachments
  - ❑ List of attachments
    - ❑ Form 1: Organization Staffing Roster

Submit to: Division of MH, DD, and AD
Systems Design & Medicaid Coordination Section
ATTN: Medicaid Application Processing
2 Peachtree Street, Suite 23-247
Atlanta GA 30303

New Provider for Mental Retardation
Home and Community Based Services Waiver Service Provision
Application Checklist

- ❑ 2 copies of your application, each in a 3-ring binder, sized appropriately to the documents submitted organized as follows:

- ❑ Cover page

- ❑ Form 6: Mental Retardation Home and Community Based Services Waiver Request for New Site/New Service Procedure Codes and Services
  - ❑ Signed by a regional staff member in a management position

- ❑ Form 7: Mental Retardation Home and Community Based Services Waiver Request for Proposed Services and Locations

- ❑ Tab: Georgia Division of Medical Assistance "Provider Enrollment Application Package"
  - ❑ Provider Enrollment Application (DMA-001)
  - ❑ Statement of Participation (DMA-002)
  - ❑ Request for Taxpayer Identification and Certification
  - ❑ Disclosure of Ownership and Control Interest Statement
  - ❑ Electronic Funds Transfer Agreement (DMA-405)
  - ❑ Provider Electronic Funds Transfer Information (DMA-406)
    - ❑ Voided check or bank specification sheet attached
  - ❑ Optional forms
    - ❑ Power of Attorney for Electronic Data Interchange
    - ❑ Power of Attorney for Payee

- ❑ Tab: Application to Provide Mental Health, Developmental Disabilities and Addictive Disease Services
  - ❑ Section 1: Application Form
    - ❑ Signed and notarized

- ❑ Tab: Plans of Care
  - ❑ Physical health issues
  - ❑ Behavioral health issues

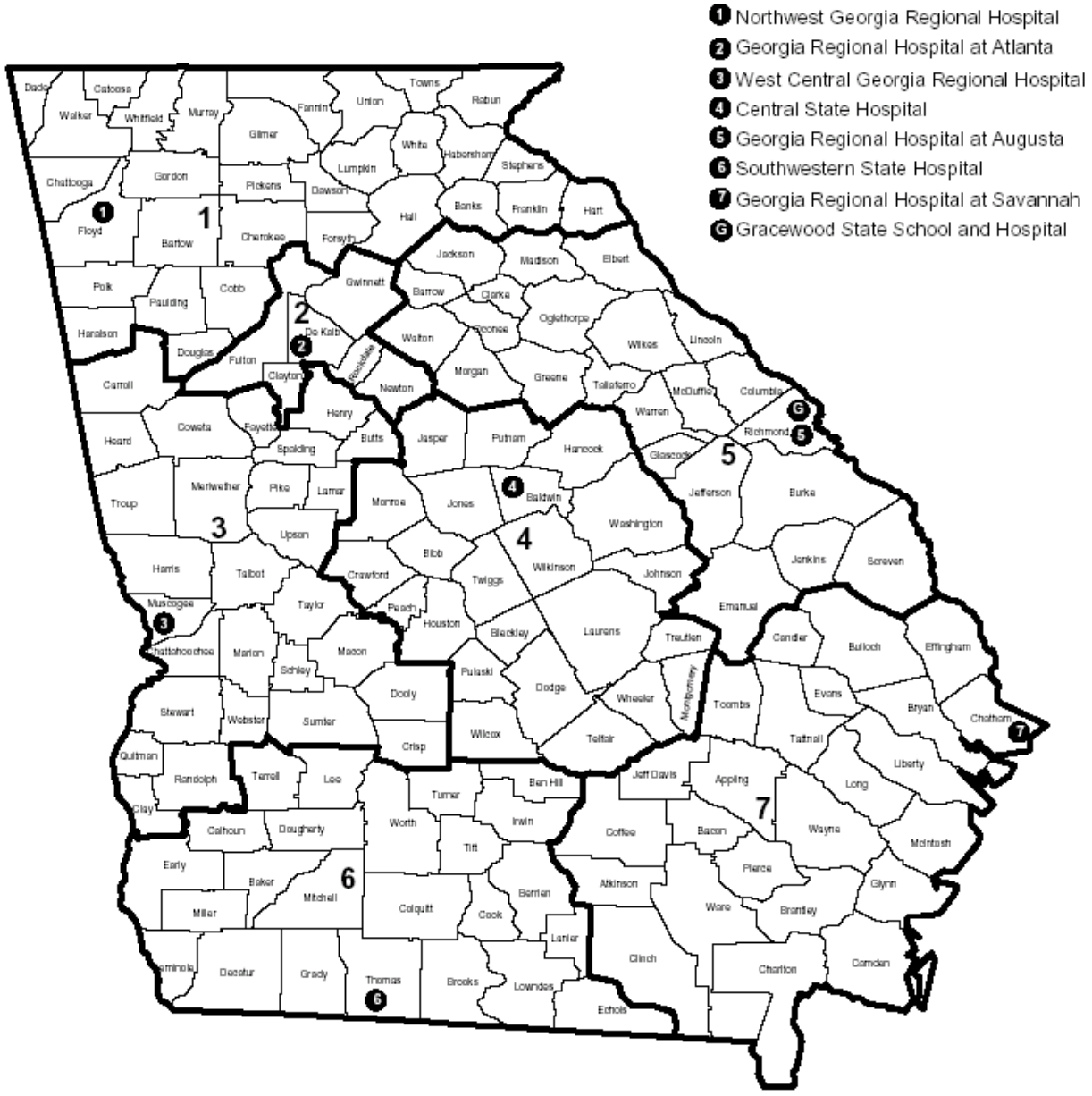
- ❑ Tab: Attachments
  - ❑ List of attachments
    - ❑ Form 1: Organization Staffing Roster

Submit to: Division of MH, DD, and AD
Systems Design & Medicaid Coordination Section
ATTN: Medicaid Application Processing
2 Peachtree Street, Suite 23-247
Atlanta GA 30303

Appendix D

Map of Regions

REGIONAL MAP
Georgia Department of Human Resources
Division of Mental Health, Developmental Disabilities & Addictive Diseases
ADOPTED AUGUST 21, 2002



Georgia Department of Human Resources
Division of Mental Health, Developmental Disabilities
and Addictive Diseases
Decision Support Section

Created August 21, 2002